NATIONAL NURSING AUDIT MINISTRY OF HEALTH MALAYSIA

ELEMENT 5: **CONTINUUM OF CARE**

5.3 ASEPTIC WOUND DRESSING

1. INTRODUCTION

Wound dressing is a core nursing responsibility that requires the use of aseptic technique. The primary goal of aseptic technique is to protect the patient from infection.

Aseptic technique refers to a set of practices aimed at preventing healthcare-associated infections in patients and protecting healthcare workers (HCWs) from exposure to blood, bodily fluids, and tissues (Australian Commission on Safety and Quality in Health Care, 2021).

Minimizing microorganisms on hands through proper hand hygiene is essential before and after performing any clinical procedure. This practice ensures that healthcare workers maintain clean hands at all times, which is crucial for infection prevention and control (Ministry of Health Malaysia, 2019).

2. OBJECTIVES

2.1 The objective of wound dressing is to promote optimal healing, protect the wound from infection, control exudate, provide a physical barrier to external contaminants, and manage pain or discomfort associated with the wound.

2.2 Proper dressing techniques also aim to maintain a moist environment conducive to healing and minimize the risk of complications such as delayed healing or scarring.

3. METHODOLOGY

3.1	Design	:	Direct observation of registered nurse performing wound dressing
3.2	Setting	:	Hospital/ Institution
3.3	Inclusion criteria	:	All patients with wounds
3.4	Exclusion criteria	:	Burn wounds and infectious cases requiring isolation
3.5	Population	:	Registered nurse
3.6	Sample design	:	Convenient sampling
3.7	Sample size	:	30% of registered nurse in hospital/ institution
3.8	Frequency	:	Once a year
3.9	Duration	:	2 months
4.0	Instrument	:	Check list (E5 AF5.3 Pind.1/2026)

4. STANDARD

≥95% compliance to standard of surgical aseptic technique during wound dressing.

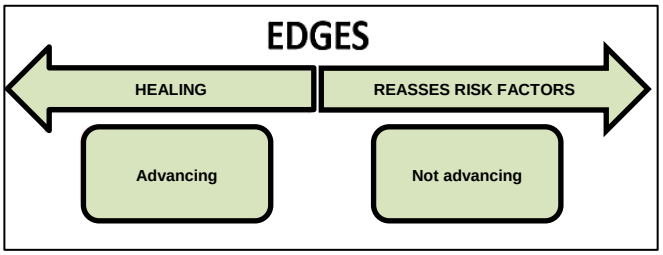
5. DEFINITION OF OPERATIONAL TERMS

NO	TERMS	DEFINITIONS
1.	HAND HYGIENE	Washing hands with soap and water, or other detergents containing an antiseptic agent (World Health Organization, 2009).
2.	MAINTAIN STERILE FIELD	A sterile field refers to a designated area that is free from microorganisms, where sterile instruments, dressings, and supplies are placed

		for medical or surgical procedures. This area is maintained using aseptic techniques to prevent contamination and infection. The sterile field is created by covering the surrounding environment with sterile drapes and ensuring that all items within it are sterile. **This includes the followings:** Sterile field refers to the area within the sterile packaging, i.e.; 1 inch around the working area be kept free of instruments. • Ensure body/ any part of uniform of nurse does not touch sterile field. • Hands do not cross sterile field at all times.
3.	CORRECT ASEPTIC TECHNIQUE	This includes the followings: • Apply correct sterile technique when opening sterile set i.e.; a. Open the pack: unwrap folded layers of wrapping material away from the center of the pack. b. Touching only the outside edges of the wrapping material. c. Pull edges toward your body keeping the pack at arms' length away. d. Unwrapped the far side by reaching your arm around the pack. e. Unwrap the left and right side follow by near side. • Keep forceps facing downwards and above waist line. • No contact of forceps when transferring soft dressing from one hand to another. • Soiled forceps should be discarded.

		• Swab from clean area to dirty area. • Keep forceps facing downwards and above waist line. • No contact of forceps when transferring soft dressing from one hand to another. • Use one swab for each stroke.
4.	ASSEMBLE NECESSARY ITEMS USING A NON-TOUCH TECHNIQUE	• The right quantity of soft dressing (cotton/ gauze/ Gamgee) is added into sterile field without contamination • When pouring cleansing solution, the pouring container should not touch the receiving container. Avoid splashing and spillage.
5.	ACCURATE AND COMPLETE DOCUMENTATION	This include the followings: • Wound size and depth. • Nature of the wound includes swelling, dirty, clean, slough, gangrene, healing process and nature of discharge - smell, color, serous, bloody, pus. Documentation of wound findings include (**TIME**): • **T**: Tissue: i) Viable - granulation and new epithelial ii) Non-Viable - necrotic tissue, slough tissue • **I**: Infection/ Inflammation - Signs and symptoms of infection e.g: presence of pus, pain, malodour • **M**: Moisture Imbalance - Exudate level dry/ minimal or moderate/ wet

- **E**: Epidermal margin (edges) - advancing or non-advancing
  (Wound Care Manual, First edition, Ministry of Health, 2014)



Advancing of edges can be assessed by measuring the depth (cavity/ sinus), length and width of the wound using a paper tape measure.

- **Advancing:** edges are pink. Healing is taking place.
- **Not advancing:** wound edges are characterized by being raised, rolled, red, or dusky. It is important to review the stages of wound healing and goals of wound management, and to consider any factors affecting wound healing that may not be adequately addressed (The Royal Children's Hospital Melbourne, n.d.).
- Document type of wound dressing product used.

6. WORK PROCESS

Structure
1. Screen/ procedure room.
2. Dressing trolley.
3. Hand-washing facilities/ hand rub.
4. Relevant protective personal equipment (PPE).
5. Clinical waste bin.
6. Domestic waste bin.
7. Protective cover.
8. Sterile dressing set.
9. Sterile soft dressings/ modern dressing.
10. Cleansing solution.
11. Adhesive tapes.

Process
1. Identify the right patient.
2. Identify type and site of wound dressing required.
3. Greet patient.
4. Explain the procedure.
5. Provide privacy to the patient.
6. Perform pain assessment.
7. Administer analgesic if indicated.
8. Wear surgical mask.
9. Wear plastic apron.
10. Perform hand hygiene.
11. Prepare trolley for dressing.
12. Place patient in a comfortable position.
13. Place protective cover.
14. Perform hand hygiene.
15. Open outer layer of dressing set.
16. Discard soiled dressing.

17. Assess wound.
18. Perform hand hygiene.
19. Open inner layer of dressing set.
20. Pour cleansing solution, add soft dressings/ supplementary.
21. Perform hand hygiene.
22. Wear sterile gloves.
23. Perform dressing.
24. Secure the dressing.
25. Make patient comfortable after procedure.
26. Discard, checked and precleaned used dressing set/ discard disposable dressing set.
27. Perform hand hygiene.
28. Document findings.

Outcome

1. The dressing is applied in strict adherence to aseptic technique principles.
2. The patient is kept informed about the progress of their wound.
3. The patient's comfort and dignity are prioritized throughout the procedure.
4. Wound findings and progress are accurately documented.

7. TECHNICAL SPECIFICATION FOR ASEPTIC WOUND DRESSING

Indicator	Percentage of compliance to standard for surgical aseptic technique during wound dressing.
Rationale	To ensure nurses perform wound dressing in accordance with aseptic technique principles, emphasize the importance of assessing the caring component during the procedure and ensuring accurate and complete documentation of findings in the patient's medical record.
Definition	**A wound** is an injury to the integument or underlying structures. It is the visible result of individual cell death or damage, which may or may not cause loss of skin integrity and impairment of the tissue's physiological function (Ministry of Health Malaysia, 2014) The **aseptic technique** is a method used to prevent the transmission of microorganisms from various sources to a patient by creating a microorganism-free environment, maintaining the sterility of instruments, and preventing microbial contamination during clinical procedures (Ministry of Health Malaysia, 2019). Hand hygiene is essential before and after performing any clinical procedure to minimize microorganisms on the hands (Ministry of Health Malaysia, 2019). Aseptic technique is a set of practices that protect patients from healthcare-associated infections and protect healthcare workers (HCWs) from contact with blood, body fluids, and body tissues (Australian Commission on Safety and Quality in Health Care, 2021).

Criteria	**Inclusion:** All patients with wounds **Exclusion:** Burn wounds and infectious cases requiring isolation
Numerator	Total conformance of items
Denominator	Total number of items
Formula	$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$
Standard	**≥ 95%**
Data Collection	1. **Where:** Data will be collected from hospital/ institution 2. **Who:** Data will be collected by the NNA Committee in the hospital/ institution. 3. **How to collect:** Audit Form (E5 AF 5.3 Pind.1/2026) 4. **How frequent:** Once a year and duration 2 months 5. **Who should verify:** All data must be verified by the Head of Nursing.
References	• Australian Commission on Safety and Quality in Health Care. (2021). *Aseptic technique.* Australian Commission on Safety and Quality in Health Care. https://www.safetyandquality.gov.au/ • Ministry of Health Malaysia. (2014). *Wound care manual (1st ed.).* Ministry of Health Malaysia. • Ministry of Health Malaysia. (2019). *Policy and procedure on infection prevention and control (3rd ed.)*. Ministry of Health Malaysia

8. AUDIT FORM

NATIONAL NURSING AUDIT MINISTRY OF HEALTH MALAYSIA	**VERSION 8/ Pind.1/2026**
ELEMENT 5 : CONTINUUM OF CARE	
TOPIC : 5.3 ASEPTIC WOUND	**DATE: 15 JAN 2026**
DOCUMENT NO : E5 AF 5.3 Pind.1/2026	

OBJECTIVES

1. The objective of wound dressing is to promote optimal healing, protect the wound from infection, control exudate, provide a physical barrier to external contaminants, and manage pain or discomfort associated with the wound.
2. Proper dressing techniques also aim to maintain a moist environment conducive to healing and minimize the risk of complications such as delayed healing or scarring.
3. Ensure accurate and complete documentation of findings in the patient's medical record.

STANDARD : ≥ 95% compliance to standard of surgical aseptic technique during wound dressing.

Date of Audit : .....

Locality : .....

Auditor : .....

Auditee : .....

N.B. Instructions for Auditors

1. To tick [√] at appropriate column.
2. S/ T/ D indicate soft skill/ technical skill/ documentation respectively.

S/N	ITEM	SOURCE OF INFORMATION	YES	NO
T1	Identify the right patient	Listen/ Observe nurse		
T2	Identify type and site of wound dressing required	Observe nurse		
S3	Greet patient	Observe nurse		
S4	Inform patient and explain procedure	Listen/ Observe nurse		
T5	Perform Pain Assessment (Provide medication if necessary)	Observe nurse		
T6	Prepare trolley for dressing	Observe nurse		
S7	Provide privacy to the patient	Observe nurse		
S8	Place patient in comfortable position and safe	Observe nurse		
T9	Place personal protective cover	Observe nurse		
T10	Wear surgical mask	Observe nurse		
T11	Wear plastic apron	Observe nurse		
T12	Perform hand hygiene	Observe nurse		
T13	Open outer layer of dressing set	Observe nurse		
T14	Discard soiled dressing.	Observe nurse		
T15	Assess wound	Observe nurse		
T16	Perform hand hygiene	Observe nurse		
T17	Open inner layer of dressing set and assemble necessary items using non touch technique.	Observe nurse		
T18	Perform hand hygiene	Observe nurse		
T19	Wear sterile glove	Observe nurse		

T20	Perform dressing:				
	T20.1	Maintain sterile field.	Observe nurse		
	T20.2	Correct aseptic technique while performing dressing	Observe nurse		
	T20.3	Apply and secure appropriate wound dressing properly.	Observe nurse		
T21	Perform hand hygiene		Observe nurse		
S22	Establish rapport with patient throughout procedure		Observe nurse		
D23	Document findings **(TIME)**:				
	D23.1	T: Tissue –Viable / Non - viable	Check documentation.		
	D23.2	I:Infection/ Inflammation	Check documentation		
	D23.3	M:Moisture Imbalance	Check documentation		
	D23.4	E: Edge of wound/ epidermal margin	Check documentation		
D24	Document the specific type of wound dressing used.		Check documentation		

AUDIT REPORT

(Please [√] the appropriate box)

Rating:

Criteria	Item	Conformance	Non conformance
Technical	19		
Documentation	5		
Soft skill	5		
Total	**29**		

Calculation: _____ X 100% = _____

REMARKS:

Auditor (name and signature) : …….

**Calculation: $\frac{\text{Total conformance of items}}{\text{Total number of items}} \times 100\%$

9. REFERENCES

Australian Commission on Safety and Quality in Health Care. (2021). *Aseptic technique.* Australian Commission on Safety and Quality in Health Care. https://www.safetyandquality.gov.au/

Ministry of Health Malaysia. (2014). *Wound care manual (1st ed.).* Ministry of Health Malaysia

Ministry of Health Malaysia. (2019). *Policy and procedure on infection prevention and control (3rd ed.)*. Ministry of Health Malaysia.

The Royal Children's Hospital Melbourne. (n.d.). *Nursing guidelines: Wound assessment and management.* Retrieved from https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Wound_assessment_and_management/

World Health Organization. (2009). WHO guidelines on hand hygiene in health care: First global patient safety challenge - Clean care is safer care. World Health Organization.